



HospitalMD™

HMD Practice Model Overview

A Professional Hospital-based Medical Service

Proprietary and Confidential



Overview of Hospital MedicineMD (H2MD) A Revenue Solution for the Small Community Hospital

Small community hospitals (SCHs) face many financial challenges. Declining reimbursement and accelerating costs are often blamed for poor performance and financial distress, and these conditions can lead to operating losses and dismal cash flow. But operating losses and dismal cash flow are symptoms and not the real cause of financial challenges. The real cause is insufficient revenue.

We usually think of increasing revenue by adding services or physicians. And many SCHs need more physicians but don't believe that physicians can be recruited to small rural communities. This is not true. But recruiting costs, employment or practice subsidies, and 12 to 24 months to know if successful, make recruiting physicians difficult, costly, and financially risky.

A MYTH

Hospitals believe the myth that they are getting all the admissions they can get.

**Let's test the myth. Enter data in the blanks
for your hospital to make this relevant.**

Legend

IP	Inpatient
ADM	Acute IP Medical Admissions
ED	Emergency Department
NR/DC	Net Revenue per IP Discharge

INPATIENT ADMISSIONS GROWTH POTENTIAL

- A. Approximate population of service area ⁽¹⁾ _____
- B. Population-based IP ADM potential [A x 0.1169] ⁽²⁾ _____
- C. Your total actual IP ADMs (direct and thru ED) _____
- D. Improvement Potential [B – C] ⁽³⁾ _____
- E. Dollar value of improvement potential [D x your \$NR/DC] ⁽⁴⁾ \$ _____

ED PATIENT VISIT GROWTH POTENTIAL

- F. Population-based ED patient visit potential [A x 0.4] ⁽²⁾ _____
- G. Current actual ED patient visits _____
- H. Improvement potential [F – G] ⁽³⁾ _____

NOTES: (1) Enter the population of your service area. Use the separate populations for your "primary" and "secondary" service areas for contrast. There are opportunities to increase your service area that we would like to discuss with you.

(2) Population-based potential based on National Center for Health Statistics, Centers for Disease Control and Prevention.

(3) The typical SCH scope of services limits your market share, but you can achieve a higher market share than you might think. We would like to discuss these opportunities with you.

(4) Use \$4,000 as an estimate if you don't immediately know your net revenue per inpatient discharge.



REVENUE POTENTIAL OF ADDITIONAL ADMISSIONS THROUGH THE ED AT VARIOUS ADMISSION RATES BASED ON YOUR CURRENT ACTUAL ED VISITS PER YEAR

INPATIENT ADMISSIONS GROWTH POTENTIAL

- I. Current ACTUAL annual ED patient visits _____
- J. Current actual annual IP ADMs through ED _____
- K. Current admission rate [J ÷ I] _____ %

Compare the admission growth potential with your current admission rate.

	<u>Additional Admissions</u>	<u>Additional Net Revenue</u>
7.0%	_____ (1)	\$ _____ (2)
8.0%	_____	\$ _____
9.0%	_____	\$ _____
10.0%	_____	\$ _____
11.0%	_____	\$ _____
12.0%	_____	\$ _____
13.0% (National average)	_____	\$ _____
14.0%	_____	\$ _____
15.0%	_____	\$ _____

NOTES: (1) $(7.0\% - K) \times I$.
 (2) Multiply the answer to Note 1 by your NR/DC or use \$4,000 as an estimate.

The reality of the rural market is that revenue erodes over time. The symptoms of declining volume are visible but erosion’s causes are not easily recognized. Erosion is the subtle decline of current inpatient revenue streams, and occurs due to out migration of patients to larger, neighboring hospitals. The causes of erosion-related financial difficulties are complex, and are significantly different in the rural market than the causes found in larger, urban hospital markets. However, whether simple or complex, the solution must stop revenue erosion. Once erosion is stopped, adding services and/or physicians could then be considered.

- L. Potential primary care physicians supported by your market. $[A/100,000 \times 83]$ _____
- M. Your current number of primary care (family practice, and internal medicine) physicians _____
- N. Potential for additional primary care physicians $[L - M]$ _____

SOURCE OF OUT MIGRATION

Out migration occurs in two places: (1) erosion of direct admits, and (2) admissions “leakage” through the Emergency Department (ED). The primary causes of direct admission erosion are (a) inconvenience of rounding in light of low reimbursement and the time it takes to round, and (b)

the inconvenience to the physician of unattached call. These conditions impact primary care physicians (PCPs) with mature, well established office practices as well as younger physicians with growing practices.

Leakage may be the most vexing and least understood cause. **Leakage occurs when patients come through the ED that qualify as inpatient admissions but are not admitted** resulting in low ED admission rates through the ED. Patients are often discharged instead to home or to the patient's doctor's office.

TREATMENT DELAYS

Some patients can be treated on an outpatient basis. In many cases, however, outpatient treatment is delayed. By the time the patient is seen by his/her PCP or presents again at the ED, the patient's condition worsens. This usually requires care available only at a larger urban hospital, and the local hospital loses the revenue opportunity. **SADLY FOR THE PATIENT, THE PATIENT OFTEN SUFFERS AS THE CONDITION WORSENS DUE TO DELAYED CARE. IRONICALLY, AND CONTRARY TO THE GOALS AND EXPECTATIONS OF ALL PAYERS (ESPECIALLY MEDICARE), THE SUBSEQUENT TOTAL COST TO THE PAYER OF DELYING CARE FOR THIS MORE SERIOUS ILLNESS IS USUALLY GREATER THAN IF TREATED AT THE ONSET IN THE LOCAL SCH.**

NOT BENIGN

Low ED admission frequency sounds very benign. However, the ED admissions rate in most SCHs is about half the national average of 13%. There is no health utilization data that indicates that the acuity of the SCH ED patient is different than the non-trauma patients of the urban ED. And physicians that work both rural and urban EDs do not support the theory that the average acuity is materially different if this theory were true. A sample of 100 people in the urban population is not generally sicker than a sample of 100 people in the rural population. Furthermore, many HospitalMD (HMD) physicians routinely admit 13% to 18% with no compliance deficiencies.

TRADITIONAL ED PHYSICIAN ROLE

The traditional Emergency Medicine (EM) physician is that he/she provides "coverage" for the ED. This means the physician is available generally to stabilize and discharge emergency patients. But only about 15% to 20% of all ED patients are true "emergencies." "Treat'em and street'em" is a phrase commonly used to illustrate the EM philosophy. Admission philosophy is physician specific. It is not uncommon to find EM physicians with widely varying admission rates in the same way as primary care physicians often have widely varying admission rates.

CONFLICT OF INTEREST

The hospital is a business, and a physician's practice (even a hospital-based physician's practice) is a business. These two different businesses can have very different goals. Hospitals' financial best interests are served by keeping the patient's stay short and minimizing the cost per patient-day. Physicians' financial best interests are best served by keeping the patient in the hospital as long as permitted.

PAY DISINCENTIVE

Unlike most office-based physicians in a small community, the EM physician is typically paid by the hour. Research and empirical evidence tell us that hourly pay (as well as salaries) alone is not an incentive for high performance, and may even be a disincentive to some. Even Medicare recognizes this phenomenon by recently instituting “pay for performance.” Most of us do what is in our best interests. Physicians earn income only when they perform a CPT event and/or write an order. And it typically takes an average of about five (5) minutes of the physician’s time per patient for the typical ED visit; whereas, a physician can easily spend 45 minutes to an hour on an admission. Thus, the EM physician has little motivation to assert extra effort on behalf of the hospital or the office-based physician.

SERIOUS IMPACT

SCHs typically get a minimum of 50% of their admissions through the ED and some get up to 90%. Therefore, weak ED admissions production can have a significant adverse financial impact. All of these causes of out migration (erosion) can be corrected.

A. SOLUTION

UNIQUE EXPERIENCE

HMD’s principals have owned and managed SCHs. This has provided us with experience that enables us to directly relate to, and understand, the difficulties of the SCH. It has further provided us unique insight into the (1) causes of insufficient revenue, and (2) need for physician leadership. Out of our experiences, we have developed a strategy that enables a SCH to play “offense” and better control its destiny. This strategy is **Hospital MedicineMD (H2MD)**, which is a unique, hospital-based medical practice designed to specifically meet hospitals’ financial needs.

COST vs. REVENUE vs. ROI

Many hospitals view the ED as a “cost” because the “cost” typically exceeds revenues. This inordinate cost is accepted because the ED is the gate through which 50% to 90% of most SCH’s inpatient admissions come. Our model yields a “net revenue” because the growth in additional revenue far exceeds the cost of our service. The typical range of H2MD return-on-investment (ROI) is 200% to 800%.

RISKY FINANCIAL VACUUM

An effective balance between medicine and business continues to be of paramount importance for hospitals and their hospital-based medical practices. The hospital typically has little control over revenue generation, efficiency, or the absolute cost of services provided by independent physicians. A physician performing complex medical services in a “financial” vacuum is risky. And in light of the risk, the goals of hospitals and physicians are not typically aligned. HMD’s practice model brings these separate sets of goals and needs into alignment to ensure that physicians’ decisions are medically and financially beneficial to the hospital, the physician, and the patient.

HYBRID x 2

H2MD is much broader in scope than most hospital-based EM services. Our model is one in which Hospitalist (inpatient) services are provided as a separate but interdependent, integrated medical service along with traditional EM services. The interdependence and unique integration of these practices provide potential medical and financial benefits that exceed both the effectiveness and financial efficiency of two separate traditional Hospitalist and EM practices.

H2MD is also much broader in scope than other practices that combine the EM service and Hospitalist service. Our purpose is to generate and protect inpatient revenue, not “staff” your ED and inpatient service.

WHAT AND HOW

The primary purpose of H2MD is to generate and protect inpatient revenue. The goals of H2MD are to:

- Intercept patient out migration through the ED.
- Provide a convenience to PCPs to voluntarily choose HMD physicians to round on some or all of their inpatients which enables them to make more efficient use of their time, and avoid rounding and unattached call.
- Take responsibility and accountability for management and leadership of the EM service and serve as a “clinical partner” to the hospital on behalf of the hospital.

H2MD is successful for many reasons, but primarily because it:

- Generates increases in revenue within a reasonable period of time more quickly than traditional methods of recruiting PCPs, and protects market share on an ongoing basis.
- Minimizes risk by achieving results; not unfulfilled hopes and promises.
- Is accountable for achieving the hospital’s performance expectations.
- Utilizes physicians who are challenged by and enjoy (1) a combination of higher acuity outpatients and inpatients, (2) diagnosing medical conditions treatable within the hospital, and (3) treating and managing ongoing inpatient care.
- Permits a more financially and clinically efficient use of a greater number and a wider range of PCPs and sub-specialists.
- Enables a hospital to recruit PCPs, specialists, and surgeons more easily with minimal risk and eliminates the barriers of rounding and unattached call.
- Aligns the clinical and financial goals of the hospital and HMD physicians who are the catalysts for intercepting admissions.

H2MD is a “system,” and the “system” is the “solution.”

B. IMPROVEMENT OPPORTUNITIES AND FINANCIAL BENEFITS

DIRECT BENEFITS

The value of the growth potential through H2MD can be significant. Results vary due to a number of conditions. Some are beyond the control of HMD as in the case in which the ED physician

determines that the patient meets admission criteria but the local PCP insists that the patient be treated locally in the PCP's office. However, the data that follow illustrate the magnitude of this potential. The benefit illustrations based on current actual ED visits, on potential ED visits based on population, and increased admission rates are presented in **Attachments 1 and 2**.

OTHER BENEFITS

H2MD is the foundation for additional revenues from other sources including:

- Medical Staff growth
- Growth in scope of services such as outpatient diagnostic ancillary service, surgery/special procedures, and inpatient ICU or CCU
- Improved physician documentation

Some additional revenues depend on factors that are not within HMD's full control, but many within our ability to initiate and influence. **Attachment 3** illustrates the success hierarchy. Indirect benefits by party are listed as follows:

Hospital

- Reduce cost per inpatient discharge
- Increase ED visits
- Reduce ED length of stay (LOS)
- Reduce the cost per ED visit
- Increase case mix by treating more seriously ill patients
- Reduce ED-related bad debt
- Increase surgery and procedures
- Improve patient satisfaction
- Quicker first interventions
- Reduce revisits and readmissions
- Reduce medication errors
- Facilitate recruiting physicians
- Facilitate discharge planning
- Improve communications and documentation
- Nurses favor Hospitalists
- Reduce clinical variation
- Increase scope of services
- Keep more patients close to home

Physicians

- Improve quality of life by eliminating rounding, "unattached call", and intrusive phone calls
- Minimize malpractice risk
- No financial deterioration of practice
- Improve financial efficiency (income per hour worked)
- Have freedom to admit own patients on suitable frequency
- Practice volume growth at no additional cost
- Retain clinical autonomy
- PCPs can keep more patients close to home
- No patient loss. All inpatients are returned to the PCP
- Makes attracting and retaining specialists and sub-specialists easier
- Ensure quality and compliance through oversight of H2MD practice
- H2MD an extension of your office practice



Patients and Families

- Improve the immediacy of care, particularly when admitted through the ED
- Permit greater continuity of care
- Improved health status and shorter lengths of stay
- More time for patient and/or family
- Reduce diagnostic and treatment variation
- Permit local care for more complex illnesses and keep more patients close to home and family
- Reduce inappropriate readmissions
- Reduce mortality
- Reduce average LOS
- More frequent patient oversight
- Improve patient satisfaction

C. RETURN ON INVESTMENT (ROI)

The return-on-investment (ROI) can vary widely based on the past financial and operational experience and performance of the hospital. Our experience has been that the ROI typically will be in the range of 200% to 800%. Thus, for each \$1 on incremental additional cost of H2MD, the hospital could realize an additional \$3 to \$9 in net revenue.

D. HMD EXPERIENCE AND REFERENCES

We have achieved significant experience and results for other clients. We will provide references upon request and as appropriate.

E. SCOPE OF SERVICES

H2MD provides EM services and Hospitalist services from a single integrated medical practice. The EM service provides the usual and customary services for a hospital of your size, and the Hospitalist service includes those usual and customary inpatient services for a hospital of your size. Inpatient care is provided on a voluntary basis to any member of the Medical Staff. These inpatient services include medical, surgical, and intensive/critical care. The EM service is staffed as a rule with Board Certified Internists but exceptions are possible under certain conditions. Other scope of service needs of the particular client are incorporated based on client's need. Our services are provided 24 hours a day, 7 days a week, 365 days a year; and include 8,760 MD hours per year (24 x 365).

F. UNIQUE PRACTICE MODEL

Hospital-based medical practices present difficult challenges to hospitals. Physicians within such practices work under the authority of policies and guidelines of the hospital whose financial success the physician affects. Their personal financial motivation versus what's best for the hospital, and their role as part of a "fragmented" continuum of care over which they individually have little influence often conflict.

H2MD's success is due largely to the unique structure of our practice model in addressing these dysfunctional conditions and constraints. This practice structure has two (2) components:

- Our proprietary practice management methodology.



- The quality and competence of our physicians.

There are five (5) building blocks of the successful H2MD practice.

PHYSICIAN SELECTION, DEVELOPMENT, AND RETENTION

Our physicians are the revenue engine and face of our client to the customer. Thus, effective physician selection is critical. Therefore, we employ several evaluation instruments in selecting and retaining our physicians. These instruments enable us to improve our success at selecting physicians with the appropriate attributes including:

- Interpersonal skills
- Propensity to provide high customer service
- Corporate and organizational compliance
- Decisiveness
- Personal organization skills
- Ability to function as a team member
- Admitting appropriately.
- Breadth of inpatient and outpatient medical skills.

INTEGRATION OF EM AND INTERNAL MEDICINE

The traditional model of emergency medicine and hospitalist services is that each is separate and independent both medically and financially. Therefore, admissions decisions for ED patients are often fragmented and dysfunctional, often made independently of the immediate needs of the patient and after the patient exits the ED, and/or based on convenience motives. Integrating both specialties into a single practice permits an improved continuity of care and ensures the best decision for the patient, the hospital, and the physician.

“BUSINESS” INFLUENCE

An effective balance between medicine and business continues to be of paramount importance for hospitals and their hospital-based medical practices. The hospital industry is unique in that it cannot generate a single dollar of revenue on its own authority. A physician must write an order. Ironically, physicians have no financial risk of the hospital (unless owners) but have a greater impact on hospitals’ revenues and costs than any other party. The most significant areas of impact include:

- Typically have no training or exposure to business practices on the scale of a SCH.
- Drive the cost of the patient encounter by his/her medical (diagnostic and treatment) decisions with no personal risk (unless an owner).
- Very little technical knowledge of how billing, coding, and collections are affected by their medical decisions and how to document to bill and collect effectively.

With so little control over revenue generation, efficiency, or cost of providing services, independent physicians performing complex medical services in a “financial” vacuum is risky. And given this risk, the goals of hospitals and physicians are not mutually aligned. HMD’s practice model brings these separate sets of goals and needs into alignment to ensure that both the hospital and physicians are mutually successful and that physicians’ decisions are medically and financially beneficial to all parties.

Another element of our integration of business and medicine includes a marketing program developed jointly with the client to introduce and promote the new practice, the physicians, and the new capabilities; and to establish awareness among the public and members of the Medical Staff. This marketing project is funded in part by HMD but requires the cooperation and collaboration of the client.

PRACTICE AUDITS

Independent audits are an integral part of maintaining the quality and integrity of any business. The practice of medicine is technically and financially complex. Therefore, we conduct audits (often using outside independent organizations) of the quality of our medical practices and documentation. We review the scope of these audits with our client to ensure that we address our client's concerns and needs.

❖ With respect to medical practices, the purposes of our medical audit are to determine:

- The quality and effectiveness of our practice.
- The effectiveness of our relationships with our client.

The audit is designed to assess our effectiveness in areas including, but not limited to:

- Practice development and organizational effectiveness.
- Client Medical Staff By-Laws, Rules and Regulations.
- Performance improvement, peer review, and risk management policies.
- Adherence to "standards of care" established by professional organizations of our medical specialties and regulatory agencies.
- Staff credentials, resource levels, medical direction, and communications methods.
- Coordination and communications with attendings, nurses, and sub-specialists.
- Medical necessity and treatment.
- Continuity of care.
- Cooperation and collaboration with case management and utilization review.
- Hospital documentation policies and practices (see paragraph that follows related to fiscal and regulatory practices).
- Patient care protocols, standardization of care, and efficiency practices.

❖ With respect to fiscal and regulatory compliance practices, the purposes of our audit are to:

- Determine the quality and effectiveness of our regulatory compliance.
- Assess the relationship between medical decisions and the revenues and costs associated with our medical decision.

Our audit included, but is not limited to:

- Adequacy, accuracy, and completeness of documentation to support ICD-9-CM (and ICD-10-CM) and CPT coding
- Documentation of appropriate multiple diagnoses
- Legibility of physicians' documentation
- Appropriateness and documentation of physicians' orders
- Efforts to maximize reimbursement

- Consistency of documentation among physicians.

The audit will identify deficiencies and improvement opportunities in each of these areas of inquiry, and develop corrective actions.

REWARD FOR PERFORMANCE

The misalignment of physician compensation and the financial needs of the hospital is referred to earlier in this document and is not repeated here. As a remedy, HMD has structured compensation to reward the physician in line with his/her performance and quality of care in a manner similar to a private office practice. This eliminates conflict which can often catch the patient in the middle and can result in medical treatment decisions that are not optimal or in the best interest of the patient.

G. DELIVERABLES

We believe an important distinction of HMD is that we take the initiative and lead in delivering “tangible” services and in achieving performance. We don’t “staff” your ED, we “manage” your EM service.

Not all benefits can be achieved at all hospitals to the same degree due to:

1. The hospital’s historic financial and operational performance.
2. Scope of services limitations.
3. Demographic attributes of the service area.
4. Limitations imposed by office-based physicians (both PCP and specialists).

However, the most common and most significant potential deliverables are listed as follows:

- Provide High Quality Physicians – Typically Board Certified or eligible Internists with Emergency Medicine and Inpatient care experience and with credentials suitable to hospital, and with care experience and skills that elevate the expectations and perceptions of the public in general and patients/customers in particular regarding the quality, efficiency, and satisfaction of patient care.
- Increase ED visit volume.
- Increase inpatient volume.
- Improve Admission Decisions and Documentation - Provide ED physicians with admission criteria reference info to identify admission prospects and to ensure that inpatient admission decisions are accurate and documented.
- Attract Sub-specialists – HMD service makes attracting sub-specialists much easier because HMD permits them to be highly efficient and optimize their income.
- Assist to elevate acuity.
- Reduce patient average length of stay (ALOS) – Provide process protocols and process management decision rules that have the potential to significantly reduce ALOS.
- Increase Revenue - Increase revenue related to volume increases noted above, AND increase average revenue per inpatient discharge and average revenue per ED visit.
- Marketing – Develop and implement a marketing program to increase utilization of Hospital. Plan components include advertising (e.g., MD credentials and services) and



publishing in the local newspaper, speaking opportunities, community education, and community physicians education.

- Physician Education – Improve methods of continuing education, and establish expectations of clinical competence and use of best medical practices.
- Clinical Protocols and Pathways – Provide clinical protocols and pathways that guide physicians to conform to best medical and financial practices.
- On-site Medical Director – Select an on-site Medical Director to represent the practice to the hospital and Medical Staff, who will attend all Medical Staff meetings and other clinical meetings as required by hospital.
- Corporate Medical Direction – Provide independent, outside medical oversight (medical conscience) of physicians.
- Medical Practice Audit – Discussed in Section G.4.
- Customer Satisfaction – Establish appropriate satisfaction measures, collect and evaluate data/info, and improve customer (patient and physician) satisfaction.
- Practice Management – Conduct periodic meetings with Hospital to develop plans aimed at improving mutual success, reviewing performance, and developing corrective action.
- Fiscal and Regulatory Audit – Discussed in Section G.4.
- Cost Reporting – Develop data for reporting ED MD unproductive time.
- Peer Review System - Establish a 360 peer review system wherein patient care charts are reviewed and analyzed daily by physicians and corrective action plans are developed, implemented, and monitored.
- Performance Improvement (PI) – Implement HMD’s proprietary PI system that monitors clinical, financial, and operational indicators.
- Disaster Plan - Assistance with development of Hospital’s disaster plans.
- Recruiting Assistance – Assist as needed, requested to recruit additional PCPs and sub-specialists to hospital’s Medical Staff.
- Medical malpractice insurance for all physicians that provide services on behalf of HMD.
- Assist to Improve Customer Service, Reduce ED ALOS, and Increase Efficiency – Provide project management and proprietary process management systems to increase customer service (RN and MD interaction with customer/patient, reduce LOS, and increase efficiency).
- Assist Hospital to Implement ED Bad Debt Reduction Practices – Provide hospital with our experience in changing the ED patient care processes to reduce bad debt.



ATTACHMENT 1



ATTACHMENT 1

GROWTH ILLUSTRATION FOR A HYPOTHETICAL HOSPITAL (Annualized Data)

LEGEND

Inpatient (IP)
Acute IP Medical Admissions (ADMs)
Emergency Department (ED)

Primary Service

Area (PSA)

INPATIENT ADMISSIONS GROWTH AND REVENUE POTENTIAL

A	Approximate population ⁽¹⁾	27,000
B	Population-based IP ADM potential [A x 0. 1169] ⁽²⁾	3,156
C	Total actual IP ADMs (direct and thru ED)	<u>1,150</u>
D	Improvement potential [B – C]	2,006
E	Dollar value of improvement potential [D X \$4,000] ⁽³⁾	\$8.0M

ED PATIENT VISIT GROWTH POTENTIAL

F	Population-based ED patient visit potential [A x 0.4] ⁽²⁾	10,800
G	Current actual ED patient visits	<u>8,000</u>
H	Improvement potential [F – G]	2,800

NOTES:

- (1) Data would be provided by client.
- (2) Population-based potential (40% of population become ED visits; and 11.69% of population are admitted) based on National Center for Health Statistics, Centers for Disease Control and Prevention.
- (3) Dollar value of improvement potential based on an average net revenue per medical IP discharge of \$4,000 used as an estimate in lieu of a client's actual.



ATTACHMENT 2



ATTACHMENT 2

Illustration 1

FINANCIAL BENEFIT ILLUSTRATION FOR A HYPOTHETICAL HOSPITAL – CURRENT ACTUAL ED VISITS OF 8,000

Actual Annual

Current ACTUAL ED patient visits	8,000
Current actual IP ADMs thru ED	488
Admission rate	6.1%

REVENUE POTENTIAL OF ADDITIONAL ADMISSIONS AT VARIOUS ED ADMISSION RATES BASED ON 8,000 CURRENT ED VISITS PER YEAR

	<u>Additional Admissions</u>	<u>Additional Net Revenue</u>
7.0%	72 ⁽¹⁾	\$288K ⁽²⁾
8.0%	152	\$608K
9.0%	232	\$928K
10.0%	312	\$1.2M
11.0%	392	\$1.6M
12.0%	472	\$1.9M
13.0% (National average)	552	\$2.2M
14.0%	632	\$2.5M
15.0%	712	\$2.8M

NOTES:

(1) 8,000 ED visits per year x 7.0% admission rate = 560 – 488 = 72.

(2) 72 additional admissions per year x an estimate of \$4,000 net revenue (in lieu of clients actual net revenue) = \$288,000.



Illustration 2

FINANCIAL BENEFIT ILLUSTRATION – ADDITIONAL ED VISITS

POTENTIAL ANNUAL

Potential ED patient visits	10,800 ⁽¹⁾
Current actual IP ADMs thru ED	488
Admission rate	4.5%

REVENUE POTENTIAL OF ADDITIONAL ADMISSIONS AT VARIOUS ED ADMISSION RATES BASED ON 10,800 POTENTIAL (BASED ON POPULATION) ADDITIONAL ED VISITS PER YEAR

	<u>Additional Admissions</u>	<u>Additional Net Revenue</u>
7.0%	268 ⁽²⁾	\$1.1M ⁽³⁾
8.0%	376	\$1.5M
9.0%	484	\$1.9M
10.0%	592	\$2.4M
11.0%	700	\$2.8M
12.0%	808	\$3.2M
13.0% (National average)	916	\$3.7M
14.0%	1,024	\$4.1M
15.0%	1,132	\$4.5M

NOTES:

- (1) 27,000 service area population x 40% ED utilization rate = 10,800.
- (2) 10,800 potential ED visits per year x 7.0% admission rate = 756 – 488 = 268.
- (3) 268 additional admissions x an estimate of \$4,000 net revenue (in lieu of clients actual net revenue) = \$1,072,000.



ATTACHMENT 3



H2MDTM – A Revenue Growth and Performance Improvement Strategy Achieved Through a Hospital-based Medical Practice That Integrates a Hospitalist Service With Traditional Emergency Medicine

- Establishes a strategic and business “partnership” with hospital
- Aligns medical practice goals with hospital goals

HospitalMD (HMD) Success Model

Success Hierarchy Building Blocks

Outcomes

Performance

